

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Morning Glory Care Home	CHAPTER 100.1
Address: 91-1531 Keonekapu Street, Ewa Beach, Hawaii 96706	Inspection Date: December 3, 2020 Initial

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) WORKING DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

RECEIVED

FEB 12 2021

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. <u>FINDINGS</u> Substitute care giver (SCG) #1 and Household member (HM) - No annual physical examination. Submit a copy for each with the plan of correction (POC).	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>SCG#1 and HM obtained physical examination. In the future POC will set up a reminder a month prior to renewal date.</p>	<p style="text-align: right;">02/11/21</p> <p style="text-align: right;">STATE OF HAWAII DOH-ORCA STATE LICENSING</p> <p style="text-align: right;">21 JUN 28 AM 1:44</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (a) All individuals who either reside or provide care or services to residents in the Type I ARCH, shall have documented evidence that they have been examined by a physician prior to their first contact with the residents of the Type I ARCH, and thereafter shall be examined by a physician annually, to certify that they are free of infectious diseases. FINDINGS Substitute care giver (SCG) #1 and Household member (HM) - No annual physical examination. Submit a copy for each with the plan of correction (POC).	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I will use spreadsheet to keep track of P.E., TB & First Aid/ CPR.</p> <p>I will check spreadsheet every month for expiration dates.</p> <p>Two months before expiration, I will let SCG, HM to know that they need to update their health clearance & or First Aid/CPR.</p> <p>I will ask for a copy when completed.</p>	<p style="text-align: center;">7/15/21</p>

RECEIVED
 ARCHIVES
 DIVISION OF
 HUMAN RESOURCES

LE 6V 51 JPP 12.

Note: Reviewed. Plan of Correction on 02/10/2021

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. FINDINGS SCG #1 and SCG #2 - No screening for symptoms consistent with pulmonary tuberculosis (TB). Submit a copy for each with the POC. HM - No annual TB clearance. Submit a copy with the POC.	<p style="text-align: center;">PART 1</p> <p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Secondary Care Level 1 & 2 TB form was completed & received on 12/20/20</p> <p>HM = TB clearance was completed on 12/19/2020</p>	<p style="text-align: right;">2/11/2021</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. FINDINGS SCG #1 and SCG #2 - No screening for symptoms consistent with pulmonary tuberculosis (TB). Submit a copy for each with the POC. HM - No annual TB clearance. Submit a copy with the POC.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p style="text-align: center;">USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>for. Caregiver w/ hr. of (+) PPD I will schedule the TB test to the PE form so the physician can complete the PE & TB screen at the same time.</p> <p>for. HM I will use the spreadsheet to keep track of the TB clearance expiration.</p> <p>I will check spreadsheet every month for the exp. dates. I will know before expiring. I will let HM to know that they need to update the TB clearance.</p> <p>I will attach a copy when completed</p>	<p>7/15/21</p>

SENIOR STATE
ARCH-DOH
STATE OF HI

LE:6V 51 TOP 12.

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 Personnel, staffing and family requirements. (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; <u>FINDINGS</u> SCG #1 - No first aid certification. Submit a copy with the POC.	<p style="text-align: center;"><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p style="text-align: center;">PART 1</p> <p style="text-align: center;">USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>SCG #1 - First aid certification was completed on 1/4/21, will schedule to complete prior to expired date.</p> <p>Kinda G. Osorio</p> <div style="text-align: right;"> STATE OF HAWAII DOH-CHCA STATE LICENSING </div>	<p style="text-align: center;">5/18/21</p> <p style="text-align: right;">21 MAY 19 P2:51</p>

RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/> §11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall: Be currently certified in first aid; FINDINGS SCG #1 - No first aid certification. Submit a copy with the POC.	<p style="text-align: center;">PART 2</p> <p style="text-align: center;"><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p>I will use spreadsheet to keep track of first aid/CPR expiration dates. I will check the spreadsheet every month for expiration date. 1 month before expiration I will let SCG to know that they need to update their first aid/CPR certification. I will ask for a copy when completed.</p>	<p style="text-align: right;">11/5/21</p>

DHHSN3C17 31A1S
 VCHO-HQ
 HAWAII JO 31A1S

LC:6V 51 TR 12.

Licensee's/Administrator's Signature:



Print Name:

Debbie G. Osorio (Mornings Glory Care Home,

Date:

2/12/2021

Licensee's/Administrator's Signature:



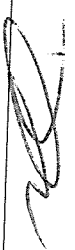
Print Name:

Mornings Glory Care Home / Debbie Osorio

Date:

2/18/21

Licensee's/Administrator's Signature:



Print Name:

Debbie Osorio

Date:

6/24/21

Licensee's/Administrator's Signature:



Print Name:

Debbie Osorio

Date:

4/15/21